

G.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.,T., Chief BUREAU DE FACILITY STANDARDS 3232 Elder Street F.O. Box 83720 Boise, ID 83720-0009 PHONE 206-334-6626 FAX 206-364-7888

November 24, 2010

Ferren Weeks, Administrator Yellowstone Group Home #1 Springfield 560 West Sunnyside Idaho Falls, ID 83401

RE: Yellowstone Group Home #1 Springfield, Provider #13G063

Dear Mr. Weeks:

Sf.q

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #1 Springfield, which was conducted on November 18, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

- 1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
- 2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- 5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

Dec 03 10 12:59p Yellowstone Group Homes S085220224

Ferren Weeks, Administrator November 24, 2010 Page 2 of 2

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by December 6, 2010, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

## www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by December 6, 2010. If a request for informal dispute resolution is received after December 6, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

BARBARA DERN Health Facility Surveyor

Non-Long Term Care

NICOLE WISENOR

Co-Supervisor

Non-Long Term Care

BD/srm Enclosures

## Yellowstone Group Homes

560 W Sunnyside Idaho Falls, ID 63402

December 3, 2010

Barbara Dem Idaho Department of Health and Welfare Bureau of Facility Standards 3232 Elder St Boise, ID 83720-0036

Dear Barbara Dem:

This is the Plan of Correction for the survey concluded at Yellowstone group Home #1 Springfield, on November 18, 2010. I would like to take the opportunity to thank you and Jim Troutfetter for the helpful information you always share. The survey process is always a learning experience, and you certainly made it helpful as well as pleasant. Thanks so much.

Sincerely,

Steve Young Administrator DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/23/2010 FORM APPROVED OMB NO. 0938-0391

TAG REGULATORY OR ISC IDENTIFYING INFORMATION)  W 000  INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey.  The survey was conducted by: Barbara Dern, QMRP, Tearn Leader Jim Troutfetter, QMRP  Common abbreviations/symbols used in this report are: ADHD - Attention Defectif Hyperactivity Disorder HRC - Human Rights Committee IPP - Individual Program Plan LPN - Licensed Practical Nurse  W 262  483.440(f)(3)(f) PROGRAM MONITORING & CHANGE  The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility's alled to ensure behavior modifying drugs were used only with the approval of the facility's HRC for 1 of 3 individuals (Individual #1 s IPP, dated 5/20/10, documented a 15 year old male diagnosed with moderate mental retardation, ADHD, and Asperger's Syndrome.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIF/CATION NUVIBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVES SIGNA			TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution rilly be excused from correcting providing it is determined that other safeguards previde sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XW3C11

Facility ID: 13G093

If continuation sheet Page 1 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED; 11/23/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING	(X3) DATE SURVEY COMPLETED
	·	13G063	B. WI	ING	11/18/2010
	PROVIDER OR SUPPLIER	E #1 SPRINGFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SPRINGFIELD IDAHO FALLS, ID 83404	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREF TAC	FIX (EACH CORRECTIVE ACTION S	HOULD BE COMPLETION
W 263	11/3/10, documenting (an antipsychotic dr. However, his record for the drug.  When asked, the LF on 11/17/10 from 4:1 was not obtained for the use Individual #1.  483.440(f)(3)(ii) PROCHANGE  The committee shour are conducted only work on the client minor) or legal guard.  This STANDARD is Based on record revice determined the facility modifying drugs were informed consent of individuals (Individual enviewed. This result an individual's rights behavior modifying drugs were informed to the facility modifying drugs were informed to consent of individuals (Individual enviewed. This result an individual's rights behavior modifying drugs were informed to a supplied the facility modifying drugs were informed to mean individuals (Individual enviewed. This result an individual #1's IPP a 15 year old male dimental retardation, A Syndrome.	d a Physician's Order, dated higher received perphenazine ug) 2 mg at bedtime. I did not contain HRC consent of the consent of perphenazine.  CRAM MONITORING &  Ild insure that these programs with the written informed of the consent of the consen	W 2	See attache Plan of Come See attach Plan of Come	
		he received perphenazine		!	·

FORM CMS-2567(02-99) Previous Versions Obsciele

EvenI ID: XW3C11

Facility ID: 13G063

If continuation sheet Page 2 of 5

PRINTED: 11/23/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE BURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 13G063 11/18/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3335 SPRINGFIELD YELLOWSTONE GROUP HOME #1 SPRINGFIELD IDAHO FALLS, ID 83404 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 263 W 263 | Continued From page 2 (an antipsychotic drug) 2 mg at bedtime. However, his record did not contain guardian consent for the drug. When asked, the LPN stated during an interview on 11/17/10 from 4:05 - 4:10 p.m., guardian consent was not obtained for perphenazine. The facility failed to ensure guardian approval was obtained for the use of perphenazine for Refer to W 262 4 W 263. Individual #1. W 312i W 312 483,450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not mel as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of an individual's IPP that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in

FORM, C.MS-25B7(02-99) Previous Versions Obsolete

Event ID; XW3C11

Facility ID: 13G063

If continuation sheet Page 3 of 5

an individual receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or

1. Individual #1's IPP, dated 5/20/10, documented a 15 year old male diagnosed with moderate mental retardation, ADHD, and Asperger's

regression. The findings include:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 11/23/2010 FORM APPROVED OMB NO. 0938-0391

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	Based on observation determined the facility and biologicals were conditions. This failty individuals (Individuals facility. This resulted the event individuals drug. The findings in During an environment on 11/17/10, from 9: the kitchen containing medications used for noted to be unlocked supervisor, who was	ental assessment conducted 45 - 10:15 a.m., a cabinet in g various over the counter routine standing orders was					

FCRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XW3C11

Facility ID: 13G063

If continuation sheet Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 11/23/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		13G063	B. WII	NG		11/	18/2010
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	, have been locked.	The maintenance supervisor if the lock and stated a	1				
	The facility failed to kept secured when	ensure all medications were not in use,					
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Event ID: XW3C11

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Facility ID: 13G063

If continuation sheet Page 5 of 5

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MM196	Guardian Is conducted only w			Jager 10	! ! !
•	16,03.11.075.10(d) Is described in writt in the facility; and This Rule is not me Refer to W312.	en plans that are kept	MM197	Ryfer to W	312
	The building and all repair. The walls an character as to perrand ceilings in kitch rooms must have sr washable surfaces. clean and sanitary, a precaution must be of insects and roder This Rule is not me		good ch Valls tility ually kept ntrance	See attack Plany Cour	tion
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PRINTED: 11/23/2010 FORM APPROVED

OF Facility Standards						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED		
	136063	T			11/18/2010	
PROVIDER OR SUPPLIER		SIREETAD	DRESS, CITY,	STATE, ZIP CODE		
WSTONE GROUP HON	NE #1 SPRINGFIE			404		
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Continued From pa	oe 1		MM380			
facility failed to ensist sanitary, and in good (Individuals #1 - #6) resulted in the environmental 10/17/10 from 9:45 the following was not a The toilet in the hat the base approximal the couch), under the unable to provide so	ure the facility was known to repair for 6 of 6 indoperation of 6 indoperation of 6 indoperation of 6 indoperation of 6 indoperation of 6 indoperation of 6 indoperation of 6 inches long.  In on the couch (when the window, was worn upport to those seated	ted on that time, a crack in facing and don it.	MINISO			
All medications in th locked area(s) exce the resident is received	e facility must be kep pt during those times ving the medication.		MM753	Refer to W3	,82	
	PROVIDER OR SUPPLIER  WSTONE GROUP HON  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa facility failed to ensistant, and in good (Individuals #1 - #6) resulted in the enviral ill-repair. The findir  1. An environmenta 10/17/10 from 9:45 the following was not the base approximate the base approximate the couch), under the unable to provide so the resident is received the resident is received the resident is received.  All medications in the locked area(s) except the resident is received.	TOP CORRECTION  13G053  PROVIDER OR SUPPLIER  WSTONE GROUP HOME #1 SPRINGFIE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENT:FYING INFORMATION OF LSC IDENT:FYING INFORMA	AT OF DEFICIENCIES OF CORRECTION  13G063  PROVIDER OR SUPPLIER  WISTONE GROUP HOME #1 SPRINGFIE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:  1. An environmental review was conducted on 10/17/10 from 9:45 - 10:15 a.m. During that time, the following was noted:  - The toilet in the hallway bathroom had a crack in the base approximately 6 inches long.  - The the left cushion on the couch (when facing the couch), under the window, was worn and unable to provide support to those seated on it.  The facility failed to ensure environmental repairs were maintained.  16.03.11.270.02(f)(i) Locked Area  All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by:	AT OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER SUPPLIER  13G063  STREET ADDRESS, CITY, 3335 SPRINGFIELD IDAHO FALLS, ID 83  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT: FYING INFORMATION)  Continued From page 1  facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:  1. An environmental review was conducted on 10/17/10 from 9:45 - 10:15 a.m. During that time, the following was noted:  - The toilet in the hallway bathroom had a crack in the base approximately 6 inches long.  - The the left cushion on the couch (when facing the couch), under the window, was worn and unable to provide support to those seated on it.  The facility failed to ensure environmental repairs were maintained.  All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by:	NT OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G083  PROVIDER OR SUPPLIER  WING  STREET ADDRESS, CITY, STATE, ZIP CODE  3335 SPRINGFIELD IDAHO FALLS, ID 83404  [CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENT:FYING INFORMATION]  COntinued From page 1  facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:  1. An environmental review was conducted on 10/17/10 from 9:45 - 10:15 a.m. During that time, the following was noted:  - The toilet in the hallway bathroom had a crack in the base approximately 6 inches long.  - The the left cushion on the couch (when facing the couch), under the window, was worn and unable to provide support to those seated on it.  The facility failed to ensure environmental repairs were maintained.  4. MM753  All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication.  This Rule is not met as evidenced by:	NOTO DEFICIENCIES OF CORRECTION  (X1) PROVIDER OR SUPPLIER  13G083  STREET ADDRESS, CITY, STATE, 2IP CODE  3335 SPRINGFIELD IDAHO FALLS, ID 83404  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (IDENT-FYING INFORMATION)  COntinued From page 1  facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:  1. An environmental review was conducted on 10/17/10 from 9:45 - 10:15 a.m. During that time, the following was noted:  - The toilet in the hallway bathroom had a crack in the base approximately 5 inches long.  - The the left cushion on the couch (when facing the couch), under the window, was worn and unable to provide support to those seated on it.  The facility failed to ensure environmental repairs were maintained.  All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by:  WAY MUTE CONSTRUCTION  STREET ADDRESS, CITY, STATE, 2IP CODE  3335 SPRINGFIELD  10AHO FALLS, ID 83404  PROVIDER'S PLAN OF CORRECTION  (RACH CORRECTIVE ACTION, SHOULD BE  (RACH CORRECTIVE ACTION, SHO

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